Primary Care Teams Committed to Reducing Health Disparities:
Equity-Oriented Primary Care Innovation & Design Collaborative

Challenge

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including lack of power and access to jobs with fair pay, quality education and housing, safe environments, and health care.[1]

Primary care clinicians and associated staff are often an individual's most frequent person-to-person contact with the medical system across their lifespan. The majority of health problems that primary care clinicians and patients face are often tied to underlying social needs. Research has shown that increased access to high-quality, primary care can improve community health and health equity.[2] This especially true among primary care systems that work in partnership with their communities to contribute to more equitable health outcomes and strengthen social and economic development.

Despite clear evidence of the benefits of primary care and other community-based social and health-related services, they have been severely under-resourced in the U.S., particularly for communities of color. Racial bias within the health care system, including primary care, has eroded the trust and use of health services, which oftentimes do not address root causes or fit the individual's needs.[3] Paired with unfair governmental policies, our healthcare system has contributed to the widening of racial and health inequities.[4] The recent COVID-19 pandemic has highlighted the need to build resilient social service and primary care systems that support under-resourced communities during a crisis. Communities of color are experiencing higher rates of mortality due to COVID-19 and more people are challenged to access essential resources including food, housing and employment.

As we work to rebuild after the pandemic, and prepare for likely future pandemics, we have an opportunity to partner with communities to ensure their primary care, public health and social service systems are designed to promote **racial equity**. This means the health care system needs to align with the priorities of the community to determine how they want to live their lives and to build systems around those priorities. *We must enable communities impacted by systems of oppression to be able to define their own health problems and co-design their own solutions with their care team* by acknowledging the role everyone plays in the healthcare system to further health equity and end the perpetuation of racism.

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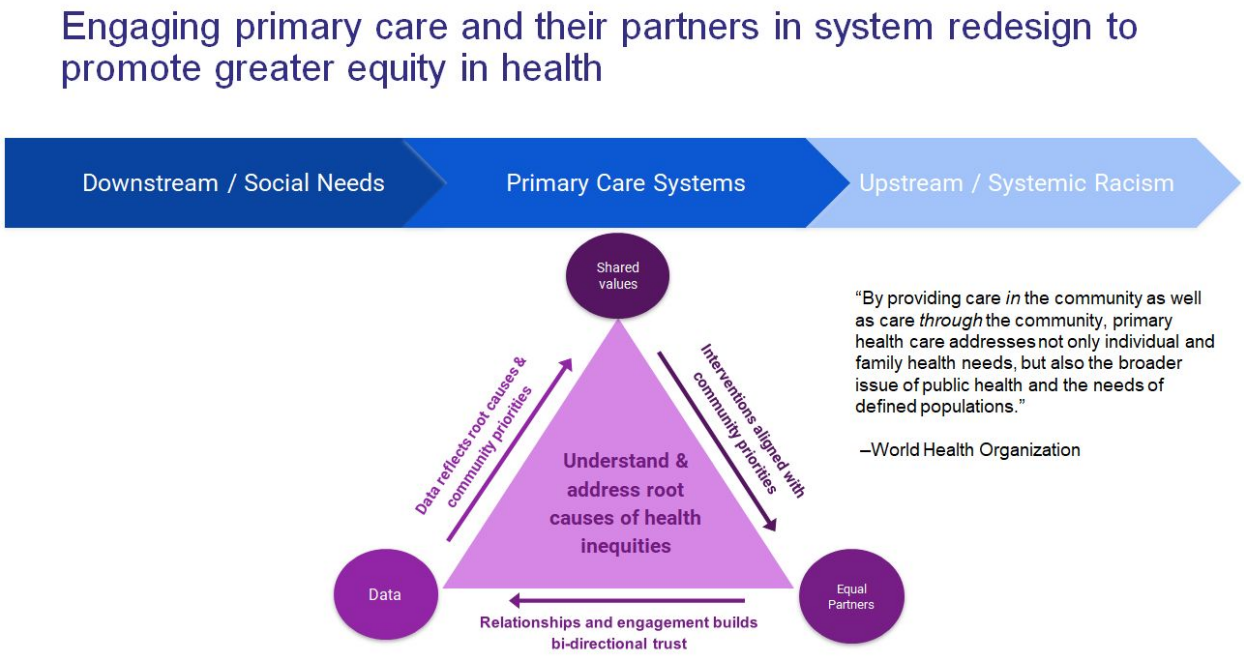
[1] Robert Wood Johnson Foundation. Accessed on 5.7.2020: https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html

[2] Starfield, B. "Primary Care and Equity in Health: The Importance to Effectiveness and Equity of Responsiveness to Peoples' Needs." Humanity & Society 33, no. 1-2 (February 2009): 56-73. DOI: 10.1177/016059760903300105

[3] Ford-Gilboe, Marilyn, C. Nadine Wathen, Colleen Varcoe, Carol Herbert, Beth E. Jackson, Josée G. Lavoie, Bernadette Bernie Pauly, et al. "How Equity-Oriented Health Care Affects Health: Key Mechanisms and Implications for Primary Health Care Practice and Policy." The Milbank Quarterly 96, no. 4 (2018): 635–71. https://doi.org/10.1111/1468-0009.12349.

[4] Marmot M. The health gap: the challenge of an unequal world: the argument. Int J Epidemiol 2017;46:1312–8.doi:10.1093/ije/dyx163 pmid:http://www.ncbi.nlm.nih.gov/pubmed/28938756

Health Leads has long been a convener and innovator at the intersection of healthcare and public health, bringing together diverse stakeholders to develop a common language in how we talk about complex issues, such as primary care. Based on learning from Health Leads' recently concluded improvement collaborative, designing new approaches will require a collaborative innovation approach that brings together multiple, multi-sector stakeholders, including those who the work is intended to benefit.



Goal

Our initiative goal is that by 2023, three primary care practices and their communities will demonstrate how primary care services can be redesigned to center on racial equity to drive measurable improvements for resilient communities of color. Through this work, we expect that:

- Individual and community level interventions will align with public health services and reduce racial bias in service delivery;
- Data-driven approaches will address root causes of health inequities and the community's priorities;
- Relationships and engagement will build bi-directional trust between community members and service providers.

This work will yield a template of innovative strategies that other primary care practices can adapt, spread, and scale to minimize the effects of systemic inequities and racial bias.

Approach

The Equity-Oriented Primary Care (EOPC) Innovation Collaborative will center racial equity in efforts to redesign systems of care to achieve health equity. Through this work, we expect that teams will develop solutions that achieve the following objectives:

- **Data-driven:** Reduce racial inequities in primary care practices by using quality measures and existing data around equity to inform interventions.
- **Co-creation:** Co-create innovations with communities so they have power and agency over their healthcare.
- **Root causes:** Design multi-level innovations that prioritize individual and community level needs and address the root causes of inequities in health outcomes.
- **Pilot:** Through innovation learnings, build feasible and sustainable pilots to share that minimizes the effects of systemic racism and bias in primary care practices.

Using a shared learning structure based in innovation and community-engagement practices, Health Leads will support three primary care practices and their community partners to design and test new processes and approaches for providing equitable care within and outside of the primary care practice. The deep innovation and prototype work within the collaborative will focus on the following areas:

1) **Institutional Racism and Bias within primary care organizations' policies and practices.** *Addressing and restructuring operational processes, internal policies, and care team-patient or family interactions to reduce bias and racism and build bi-directional trust within primary care.*
2) **Alignment of primary care strategies with community-prioritized public health efforts.** *Exploring how to better align with public health services to enhance primary prevention and reduce health disparities for communities of color. Using data to inform how to shift interventions focus on aligning multi-sector interventions that consider the community's preferences, strengths, and priorities.*
3) **Create sustainable financial models for new equitable care models.** *Use the Health Leads' business case approach to showcase the value of new equity-centered models of care to the community to support long term sustainability. We recognize that resource allocations based on current payment systems funnel funds away from activities and resources that support health. Thus, providing a business justification only to payors is insufficient, the community deserves access to resources that will support their health.*

Project Structure

From the Fall 2020 through September 2022, three primary care sites from different regions across the U.S., will collaborate with the patients they serve and other

community partners on redesigning care for a subpopulation or specific health related issue identified by the practice and its community. The primary care site, along with the patient representatives and multi-sector community partners will serve as an EOPC Innovation Collaborative site team.

Innovation Rooted in Racial Healing

Addressing root causes requires an explicit focus on racial equity. Site teams will need to work together from a place of truth, valuing lived experience as a form of expertise and sharing power equitably with others. Health Leads, in collaboration with the primary care site leads and subject matter experts will facilitate the three site teams through a robust innovation process that will yield new approaches and solutions that are new to or emerging in primary care. Innovation work will be rooted in racial healing through the development of a shared racial equity language across all participants and the creation of intentional space for participants to reflect on and discuss their relationship to racial bias, power and privilege in how they witness racial inequities in their communities and systems.

An explicit focus on racial healing will be woven throughout the innovation process. During a discovery phase, teams will explore the root causes driving inequities in health outcomes and identify which of these root causes are of highest concern to the community. Methods for discovery will engage the community at large, focus on communities' assets and strengths; utilize quantitative and qualitative methods; and build on existing evidence-based research. Site teams will then identify themes in the data used during discovery and engage the community on creating solutions that address these themes. Prototypes developed will be tested, measured, and refined. Learnings and outcomes will be shared with the community, so that solutions developed are in strong support of the community-prioritized outcomes.

Measurement & Evaluation

Measurement and data will be a fundamental component of the innovation work. Sites will collect data and report on a small set of *shared measures* and will develop and test *site-specific measures* that reflect individual teams' innovation work and outcomes of importance to the community. Among these measures will be one or more Patient-Reported Outcome Measures (PROMs)-- promising tools for improving care by measuring patients' perceptions of their own health. Sites will identify PROMs that matter to patients/community members and explore how to utilize PROMs to understand pathways to equitable health. Sites will also stratify clinical data by race/ethnicity and other demographic variables to identify gaps and develop innovative strategies to achieve equitable outcomes.

Realizing improvements in health equity through clinical and other health measures can take years to accomplish and requires significant and sustained groundwork on the part of communities to get there. To understand site teams' progress on creating sustainable structural changes that will yield improvements in health, sites will engage communities in qualitative data collection and analysis to measure changes in mindsets, actions, and conditions over time throughout the collaborative.

Shared Learning

The sites will receive individualized coaching and access to an online platform to track and share their progress and learning. They will convene periodically to hear from experts, share learning, insights and results with each other, which will enhance collective progress across the EOPC Innovation Collaborative. Health Leads will also track new knowledge and insights against its learning agenda that reflects the goals and objectives of the EOPC Innovation Collaborative.

Sustainability

The new processes and approaches developed by the site teams will likely require new resources or shifts in the allocation of existing resources and may fall outside of current reimbursement structures. To support the long-term sustainability of the new models, site teams will consider how to financially sustain the solutions developed. Health Leads' business case approach will be provided as a tool to support teams to showcase the value of new equity-centered models of care to the community and not solely to payors or individual stakeholders in a position to invest. Site teams will also explore the limitations of current reimbursement structures and identify other sources of funding for the new models and approaches. Historically, efficiency and equality discourses have driven primary care delivery and are in conflict with racial equity.[5] The new equity-centered processes and approaches will result in fundamental shifts in service delivery to be sustained over the long term. Participating primary care practices and their partners will identify what policies, processes, roles, and accountability structures need to be revised and act to make the necessary internal adjustments to support full transformation and sustainability.

Outcomes, Impacts & Learning

As a result of the site teams' deep engagement in redesigning primary care, we expect to see progress among the teams in the following areas:

1) Recognition of one's own positionality and entanglement with white supremacy and systems of oppression
2) Identification and leveraging of individuals' and communities' strengths over deficits
3) Resistance of band-aid approaches and investment in root cause solutions
4) Shared power through participatory decision making
5) Alignment of resources to reflect community need
6) Programs and services that meet people where they are and reflect individualized needs

The innovations developed through this collaborative will challenge primary care and its partners to make fundamental changes to care delivery that confront the dominant values of individualism and equality (expecting equal agency of all individuals and personal responsibility for social position and behaviors).[6] For

[5] Blanchet Garneau et al. BMC Health Services Research (2019) 19:764 https://doi.org/10.1186/s12913-019-4602-3

[6] Ibid

example, this could look like integrating strengths-based approaches to address individuals' and communities' most pressing health needs into the structures, policies and programs within and outside of the practice. Changes of this type would require sharing power and decision-making within the design of care delivery patients and communities as the norm and recognize strengths brought to the team by having these roles represented at the table.. This is different from current approaches of care delivery that focus on deficits and seeks validation from communities impacted by systems of oppression, and accommodates their unique needs on an ad-hoc basis, but do not let their preferences and priorities drive care delivery and the way primary care partners with others to support community health.

The innovative work from these practices will serve as a template to address future policy and organizational changes in the primary care system, highlighting replicable and scalable strategies to help minimize the effects of systemic racism and bias in healthcare. The change strategies, learnings and approaches developed by the practices will be compiled to promote additional learning and spread among a larger cohort of practices.

Key learnings and insights from this initial phase of work with three communities will be shared across the Health Leads Network, including in-person learning events, virtual content sharing, and learning reports. Health Leads will also collaborate with national primary care and public health partners to build a sustained movement and wider adoption of primary care systems that center racial equity in care delivery.

EOPC Participants

Health Leads' EOPC Innovation Collaborative seeks to select 3 geographically, diverse, primary care practice sites, or regional health collaborative with strong primary care partners, with at least 1 located in the southern U.S.

Interested sites must demonstrate strong leadership commitment to the following criteria:

- Based in the 50 U.S. states.
- Primary care sites provide internal medicine or family medicine services in one of the following settings: federally qualified health center, community health center, free clinic, independent practice, faculty practice or outpatient clinic attached to a larger health system.
- **Racial equity work:** Demonstrated commitment at leadership and staff levels to engage in undoing racism work, race equity and health equity. This can include: history of taking action to improve racial equity; creation of an inclusive environment where diversity is valued and seen as an asset to the organization; and issues tied to race are regularly discussed at multiple levels.
- **Data**: Willingness to gather, track, and report (to multiple audiences, including the community) qualitative and quantitative data for learning and

improvement. Ability to stratify data by race, ethnicity, and other demographic variables and to engage community members in qualitative data collection and analysis.

- **Partnerships:** Established partnerships with public health and local CBOs,* to form your site's EOPC team. Ideally, established partnerships will have some shared systems to support coordinated service delivery and staff from these organizations work together to collaborate care for shared patients and have a basic understanding of each others' roles. (*Letters of support will be required.)
- **Community Engagement:** Leadership and staff are receptive to patient and community needs and preferences and routinely engage patients and/or community members in program development and improvement.
- **Innovation work:** Willingness to engage in system redesign efforts, which will require, on average, at least 8 hours per week of dedicated staff and community member time to support the design, integration, and evaluation of new roles and processes into the existing care model. Sites will identify a population or issue to focus their innovation work. Populations of interest can be a subpopulation of internal medicine or family medicine, as long as the learnings can be spread to other populations, fit into primary care, and focus on marginalized people of color.
- **Team composition:** Sites will determine the composition of their project teams based on the scope of their innovation project. In general teams should include community members, clinical advisor/champion from the primary care practice, community health workers or other public health staff, other members of the primary care team or administration, and staff from partner CBOs and/or public health partners.
- Participating sites will receive a $180K stipend to support their work within this project over an 18 month period.

Recruitment Timeline w/ Key Dates

- November 4, 2020 to December 4, 2020 - Site team outreach and Initial screen
- December 18, 2020 - Letter of Intent Packets Due (will include statement of interest, plus Letters of Support).
- December 2020 - Review LOIs
- January 2021 - Sites virtual visits scheduled and Sites notified of acceptance.
- February 2021 - Project Launch

Who Will Benefit from EOPC

Community level: Communities of color that have historically been underinvested, underrepresented and experienced significantly higher negative health outcomes

than their white counterparts. At the community level, more power and influence over the systems individual community members interact with to ensure that services consistently meet their needs and are able to support them during a crisis.

Practice level: We anticipate that participating primary care practices will experience:

- National recognition for designing a new primary care model that can serve as a model for others.
- Support to redesign primary processes that support more efficient delivery of primary care services
- Increased capability to provide equitable services that are strongly aligned with community priorities and address underlying social needs which contribute to health outcomes;
- Increased potential for improved equity within working environments, supporting the retention of a diverse staff and patient base;
- Shared learning with and new ideas from other equity-focused primary care practices in different geographic areas;
- A unique opportunity to accelerate the practices mission and make a meaningful contribution to the vulnerable communities served;

About Health Leads

Health Leads is an innovation hub that pursues both national and local initiatives that address the deep societal roots of racial inequity that impact our health. A non-profit founded in 1996, the organization helped set the standard for health systems and clinics looking to integrate programs that connect people to essential health resources like food, heat and housing. Today, Health Leads is focused on building partnerships and redesigning systems so every person, in every community, can live with health, well-being and dignity.

Enabling primary care practices to center equity as they design new community-driven care models will require bringing together diverse stakeholders to work toward common goals. Health Leads has long served as a convener that enables stakeholders from different backgrounds to act on their role in advancing community health and meaningfully contribute to innovative solutions that drive equity.